		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0036632

Facility Name: COUNTRYSIDE HEALTHCARE CENTER

Address: 1635 EAST 154TH STREET (Number) DOLTON (City) 60419 (Zip Code)

County: COOK

Telephone Number: (847) 647-1717 **Fax #** (847) 647-0222

IDPA ID Number: 36-3730831

Date of Initial License for Current Owners: 11/01/90

Type of Ownership:

[ ]	VOLUNTARY,NON-PROFIT	[X]	PROPRIETARY	[ ]	GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code		[ ]	Corporation	[ ]	Other
		[X]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2001 to 12/31/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) SHERWIN I. RAY

(Title) PRESIDENT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)

(Print Name and Title) BOB KAGDA, PARTNER

(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124

(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number COUNTRYSIDE HEALTHCARE CENTER # 0036632 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	100	Skilled (SNF)	100	36,500	1
2		Skilled Pediatric (SNF/PED)			2
3	97	Intermediate (ICF)	97	35,405	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	197	TOTALS	197	71,905	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			1,072	1,072	8
9	SNF/PED					9
10	ICF	59,272	471		59,743	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	59,272	471	1,072	60,815	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.58%

D. How many bed-hold days during this year were paid by Public Aid?
1,138 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/01/90

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/01/90 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 12 and days of care provided 1,043

Medicare Intermediary ADMINASTAR

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number COUNTRYSIDE HEALTHCARE CENTER # 0036632 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	160,601	31,311	10,209	202,121		202,121	3,060	205,181			1
2	Food Purchase		228,232		228,232		228,232	(1,279)	226,953			2
3	Housekeeping	145,986	38,371	0	184,357		184,357	0	184,357			3
4	Laundry	62,282	19,735	0	82,017		82,017	0	82,017			4
5	Heat and Other Utilities			122,033	122,033		122,033	691	122,724			5
6	Maintenance	45,015	40,538	24,808	110,361		110,361	14,491	124,852			6
7	Other (specify):*			11,115	11,115		11,115	0	11,115			7
8	**TOTAL General Services**	413,884	358,187	168,165	940,236	0	940,236	16,963	957,199			8
	B. Health Care and Programs											
9	Medical Director	0		5,000	5,000		5,000	0	5,000			9
10	Nursing and Medical Records	1,500,800	69,913	6,675	1,577,388		1,577,388	30,708	1,608,096			10
10a	Therapy	64,914	2,514	26,014	93,442		93,442	12,018	105,460			10a
11	Activities	82,829	7,546	0	90,375		90,375	0	90,375			11
12	Social Services	254,271		722	254,993		254,993	0	254,993			12
13	Nurse Aide Training			0	0		0	0	0			13
14	Program Transportation			0	0		0	0	0			14
15	Other (specify):*				0		0	0	0			15
16	**TOTAL Health Care and Programs**	1,902,814	79,973	38,411	2,021,198	0	2,021,198	42,726	2,063,924			16
	C. General Administration											
17	Administrative	100,069		444,000	544,069		544,069	(380,929)	163,140			17
18	Directors Fees			0	0		0	0	0			18
19	Professional Services			258,070	258,070		258,070	(193,705)	64,365			19
20	Dues, Fees, Subscriptions & Promotions			62,640	62,640		62,640	(10,449)	52,191			20
21	Clerical & General Office Expenses	94,391	18,911	177,543	290,845		290,845	(85,192)	205,653			21
22	Employee Benefits & Payroll Taxes			314,214	314,214		314,214	0	314,214			22
23	Inservice Training & Education			2,323	2,323		2,323	597	2,920			23
24	Travel and Seminar			0	0		0	630	630			24
25	Other Admin. Staff Transportation			2,092	2,092		2,092	2,872	4,964			25
26	Insurance-Prop.Liab.Malpractice			253,386	253,386		253,386	5,573	258,959			26
27	Other (specify):*			0	0		0	47,427	47,427			27
28	**TOTAL General Administration**	194,460	18,911	1,514,268	1,727,639	0	1,727,639	(613,176)	1,114,463			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,511,158	457,071	1,720,844	4,689,073	0	4,689,073	(553,487)	4,135,586			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number COUNTRYSIDE HEALTHCARE CENTER #0036632 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			39,906	39,906		39,906	182,703	222,609			30
31	Amortization of Pre-Op. & Org.				0		0	0	0			31
32	Interest			37,939	37,939		37,939	591,983	629,922			32
33	Real Estate Taxes			385,937	385,937		385,937	0	385,937			33
34	Rent-Facility & Grounds			1,063,951	1,063,951		1,063,951	(1,055,855)	8,096			34
35	Rent-Equipment & Vehicles			45,650	45,650		45,650	(10,174)	35,476			35
36	Other (specify):*				0		0	0	0			36
37	**TOTAL Ownership**			1,573,383	1,573,383	0	1,573,383	(291,343)	1,282,040			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		29,838	12,228	42,066		42,066	(4,604)	37,462			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			107,858	107,858		107,858	0	107,858			42
43	Other (specify):*				0		0	0	0			43
44	**TOTAL Special Cost Centers**	0	29,838	120,086	149,924	0	149,924	(4,604)	145,320			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,511,158	486,909	3,414,313	6,412,380	0	6,412,380	(849,434)	5,562,946			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number COUNTRYSIDE HEALTHCARE CENTER # 0036632 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(10,849)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,279)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees	(325)	20		17
18	Fines and Penalties	(22,637)	21		18
19	Entertainment	0	20		19
20	Contributions	(2,859)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	0	27		24
25	Fund Raising, Advertising and Promotional	(11,548)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(1,172)	20		28
29	Other-Attach Schedule SEE PAGE 5A	(37,355)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (88,024)		$ 0	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(761,410)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (761,410)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (849,434)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS
COUNTRYSIDE HEALTHCARE CENTER
ID# 0036632
Report Period Beginning: 01/01/2001
Ending: 12/31/2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 1055	6	1
2	MARKETING	(38,410)	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(37,355)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number COUNTRYSIDE HEALTHCARE CENTER # 0036632 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	3,060	0	0	0	0	0	0	0	0	0	3,060	1
2	Food Purchase	(1,279)	0	0	0	0	0	0	0	0	0	0	(1,279)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	691	0	0	0	0	0	0	0	0	0	691	5
6	Maintenance	1,055	13,436	0	0	0	0	0	0	0	0	0	14,491	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(224)	17,187	0	0	0	0	0	0	0	0	0	16,963	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	30,708	0	0	0	0	0	0	0	0	0	30,708	10
10a	Therapy	0	12,133	0	(115)	0	0	0	0	0	0	0	12,018	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	42,841	0	(115)	0	0	0	0	0	0	0	42,726	16
	C. General Administration													
17	Administrative	0	(444,000)	63,071	0	0	0	0	0	0	0	0	(380,929)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(200,400)	6,695	0	0	0	0	0	0	0	0	(193,705)	19
20	Fees, Subscriptions & Promotions	(15,904)	0	5,455	0	0	0	0	0	0	0	0	(10,449)	20
21	Clerical & General Office Expenses	(61,047)	(118,200)	94,055	0	0	0	0	0	0	0	0	(85,192)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	597	0	0	0	0	0	0	0	0	597	23
24	Travel and Seminar	0	0	630	0	0	0	0	0	0	0	0	630	24
25	Other Admin. Staff Transportation	0	0	2,872	0	0	0	0	0	0	0	0	2,872	25
26	Insurance-Prop.Liab.Malpractice	0	0	5,573	0	0	0	0	0	0	0	0	5,573	26
27	Other (specify):*	0	0	47,427	0	0	0	0	0	0	0	0	47,427	27
28	**TOTAL General Administration**	(76,951)	(762,600)	226,375	0	0	0	0	0	0	0	0	(613,176)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(77,175)	(702,572)	226,375	(115)	0	0	0	0	0	0	0	(553,487)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number COUNTRYSIDE HEALTHCARE CENTER **#** 0036632 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(10,849)	0	193,552	0	0	0	0	0	0	0	0	182,703	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	591,983	0	0	0	0	0	0	0	0	591,983	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(1,055,855)	0	0	0	0	0	0	0	0	(1,055,855)	34
35	Rent-Equipment & Vehicles	0	(18,789)	8,615	0	0	0	0	0	0	0	0	(10,174)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(10,849)	(18,789)	(261,705)	0	0	0	0	0	0	0	0	(291,343)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	(4,604)	0	0	0	0	0	0	0	(4,604)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	(4,604)	0	0	0	0	0	0	0	(4,604)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(88,024)	(721,361)	(35,330)	(4,719)	0	0	0	0	0	0	0	(849,434)	45

Facility Name & ID Number COUNTRYSIDE HEALTHCARE CENTER # 0036632 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED SCHEDULE				CAREPLUS MGMT	NILES	MGMT/CLERICAL
				CAREPLUS REHABILITATIVE SERVICES		
					NILES	THERAPY
				COUNTRYSIDE		
				H/C LLC	NILES	REAL ESTATE

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	$ 444,000	CAREPLUS MANAGEMENT, INC.		$	$ (444,000)	1
2	V	19	ADMIN. CONSULTANT FEES	186,000	" "			(186,000)	2
3	V	19	DATA PROCESSING FEES	14,400	" "			(14,400)	3
4	V	21	CLERICAL FEES	118,200	" "			(118,200)	4
5	V	1	DIETARY CONSULTANT FEES	7,200	" "			(7,200)	5
6	V	35	COMPUTER LEASE	18,789	" "			(18,789)	6
7	V	1	DIETARY SALARIES		" "		10,260	10,260	7
8	V	5	ELECTRICITY		" "		691	691	8
9	V	6	MAIN & REPAIRS		" "		394	394	9
10	V	6	MAINTENANCE SALARIES		" "		13,042	13,042	10
11	V	10	NURSING SALARIES		" "		30,708	30,708	11
12	V	10a	THERAPY SUPPLIES/SERVICES		" "		1,661	1,661	12
13	V	10a	THERAPY SALARIES		" "		10,472	10,472	13
14	Total			$ 788,589			$ 67,228	$ * (721,361)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number COUNTRYSIDE HEALTHCARE CENTER # 0036632 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	RENT	$ 1,063,951	COUNTRYSIDE HEALTHCARE CENTER LLC		$	$ (1,063,951)	15
16	V	30	SL DEPRECIATION				180,737	180,737	16
17	V	32	INTEREST				570,618	570,618	17
18	V								18
19	V								19
20	V	17	ADMIN SALARIES		CAREPLUS MGMT INC		63,071	63,071	20
21	V	19	PROFESSIONAL FEES		" "		6,695	6,695	21
22	V	20	DUES/LICENSES/WANT ADS		" "		5,455	5,455	22
23	V	21	TOTAL OFFICE		" "		24,893	24,893	23
24	V	21	CLARICAL SALARIES		" "		69,162	69,162	24
25	V	23	SEMINARS		" "		597	597	25
26	V	24	TRAVEL		" "		630	630	26
27	V	25	TRANSPORTATION		" "		2,872	2,872	27
28	V	26	INSURANCE		" "		5,573	5,573	28
29	V	27	EMPLOYEE BENEFITS		" "		47,427	47,427	29
30	V	30	DEPRECIATION (SL)		" "		12,815	12,815	30
31	V	32	INTEREST		" "		21,365	21,365	31
32	V	34	OFFICE RENT		" "		8,096	8,096	32
33	V	35	EQUIP RENT/AUTO LEASE		" "		8,615	8,615	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,063,951			$ 1,028,621	$ * (35,330)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number COUNTRYSIDE HEALTHCARE CENTER # 0036632 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10A	THERAPY SERVICES	$ 26,014	CAREPLUS REHABILITATIVE SERVICES		$ 25,899	$ (115)	15
16	V	39	ANCILLARY THERAPY	12,227	CAREPLUS REHABILITATIVE SERVICES		7,623	(4,604)	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 38,241			$ 33,522	$ * (4,719)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number COUNTRYSIDE HEALTHCARE CENTER # 0036632 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	CAREPLUS MGMT ALLOCATIONS:								$		1
2	SHERWIN I. RAY	PRESIDENT	ADMINISTRAT,	36.17	SEE ATTACHED	6.1	10.21	SALARY	18,896	17-7	2
3			FINANCE		SCHEDULES						3
4	JAKOB BAKST	DIR OPERATIONS	ADMINISTRAT,	21.57		6.1	10.21	SALARY	18,896	17-7	4
5			CONSULTING								5
6	ROSLYN INDICH	CLERICAL	CLERICAL	2.54		6.1	10.21	SALARY	4,604	21-7	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 42,396		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number COUNTRYSIDE HEALTHCARE CENTER # 0036632 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CAREPLUS MANAGEMENT, INC.
Street Address: 5940 W. TOUHY
City / State / Zip Code: NILES, IL 60714
Phone Number: (847) 647-1717
Fax Number: (847) 647-0222

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY SALARIES	CENSUS DAYS	606,625	15	$ 83,890	$ 83,890	61,960	$ 10,260	1
2	5	ELECTRICITY	" "	606,625	15	6,767		61,960	691	2
3	6	MAIN & REPAIRS	" "	606,625	15	3,858		61,960	394	3
4	6	MAINTENANCE SALARIES	" "	606,625	15	127,691	127,691	61,960	13,042	4
5	10	NURSING SALARIES	" "	606,625	15	300,646	300,646	61,960	30,708	5
6	10a	THERAPY SUPPLIES/SERVICE	" "	606,625	15	15,283		61,960	1,661	6
7	10a	THERAPY SALARIES	" "	606,625	15	96,375		61,960	10,472	7
8	17	ADMIN SALARIES	" "	606,625	15	617,499	617,499	61,960	63,071	8
9	19	PROFESSIONAL FEES	" "	606,625	15	65,550		61,960	6,695	9
10	20	DUES/LICENSES/WANT ADS	" "	606,625	15	53,408		61,960	5,455	10
11	21	TOTAL OFFICE	" "	606,625	15	243,714		61,960	24,893	11
12	21	CLARICAL SALARIES	" "	606,625	15	677,141	677,141	61,960	69,162	12
13	23	SEMINARS	" "	606,625	15	5,849		61,960	597	13
14	24	TRAVEL	" "	606,625	15	6,170		61,960	630	14
15	25	TRANSPORTATION	" "	606,625	15	28,114		61,960	2,872	15
16	26	INSURANCE	" "	606,625	15	54,564		61,960	5,573	16
17	27	EMPLOYEE BENEFITS	" "	606,625	15	464,335		61,960	47,427	17
18	30	DEPRECIATION (SL)	" "	606,625	15	125,471		61,960	12,815	18
19	32	INTEREST	" "	606,625	15	209,175		61,960	21,365	19
20	34	OFFICE RENT	" "	606,625	15	79,265		61,960	8,096	20
21	35	EQUIP RENT/AUTO LEASE	" "	606,625	15	84,343		61,960	8,615	21
22										22
23										23
24										24
25	TOTALS					$ 3,349,108	$ 1,806,867		$ 344,494	25

Facility Name & ID Number COUNTRYSIDE HEALTHCARE CENTER # 0036632 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: COUNTRYSIDE HEALTHCARE CTR LLC
Street Address: 5940 W. TOUHY
City / State / Zip Code: NILES, IL 60714
Phone Number: (847) 647-1717
Fax Number: (847) 647-0222

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	SL DEPRECIATION	DIRECT COST	1	1	$ 141,337	$	1	$ 141,337	1
2	32	INTEREST	DIRECT COST	1	1	570,618		1	570,618	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 711,955	$		$ 711,955	25

Facility Name & ID Number COUNTRYSIDE HEALTHCARE CENTER # 0036632 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	RELATED PARTY: COUNTRYSIDE HEALTHCARE CENTER, LLC						$	$			$	1
2	CORUS BANK		X	MORTGAGE	$50,182.00	05/98	4,343,980	3,521,734	06/05	0.0939	353,534	2
3	COUNTRYSIDE PLAZA		X	JR MORTGAGE	$17,307.38	05/98	1,978,877	1,898,084	05/08	0.0950	181,676	3
4	CIB BANK		X	CAPITAL IMPROVEMENT	$11,374.45	02/01	540,000	461,214	02/06	PRIME+	34,958	4
5	LOAN COSTS		X	LOAN COSTS	W/O OVER 5 YEARS		2,700	2,250	02/06		450	5
	Working Capital											
6	CAREPLUS MGMT INC	X		WORKING CAPITAL	DEMAND	04/95	1,015,000	240,000		PRIME+	24,102	6
7	FIRST PREMIUM		X	INSURANCE FINANCING							13,837	7
8	CAREPLUS MANAGEMENT ALLOCATION										21,365	8
9	TOTAL Facility Related				$78,863.83		$ 7,880,557	$ 6,123,282			$ 629,922	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 0	$ 0			$ 0	14
15	TOTALS (line 9+line14)						$ 7,880,557	$ 6,123,282			$ 629,922	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number COUNTRYSIDE HEALTHCARE CENTER # 0036632 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 435,890	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 408,867	2
3. Under or (over) accrual (line 2 minus line 1).		$ (27,023)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 412,960	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 385,937	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	389,145	8
	1997	392,991	9
	1998	403,339	10
	1999	431,573	11
	2000	408,867	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2000 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME COUNTRYSIDE HEALTHCARE CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0036632

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200(

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	29-13-100-001-0000	NURSING HOME	$ 408,867.28	$ 408,867.28
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 408,867.28	$ 408,867.28

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services' _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill whic is normally paid during 2001.

Facility Name & ID Number COUNTRYSIDE HEALTHCARE CENTER # 0036632 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 37,547 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 0
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 0
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	132,928	1998	$ 392,750	1
2					2
3	TOTALS	132,928		$ 392,750	3

Facility Name & ID Number COUNTRYSIDE HEALTHCARE CENTER # 0036632 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5	1997		1998		5,408,525	138,675	39	138,675		502,832	5
6											6
7											7
8											8
	Improvement Type**										
9	LEASEHOLD IMPROVEMENTS			1991	24,648	783	31.5	782	(1)	8,488	9
10	LEASEHOLD IMPROVEMENTS			1992	28,172	895	31.5	894	(1)	8,538	10
11	LEASEHOLD IMPROVEMENTS			1993	11,940	337	31.5	379	42	3,221	11
12	LEASEHOLD IMPROVEMENTS			1994	4,878	125	39	125		919	12
13	TILE / ROOF VENTS			1995	16,191	416	39	415	(1)	2,709	13
14	WALL / WATER PANEL			1995	4,199	108	39	108		679	14
15	LANDSCAPING/PARKING LOT REPAIRS			1995	13,614	908	15	908		5,901	15
16	ROOF REPAIRS			1996	13,369	343	39	343		1,930	16
17	SINK			1996	683	18	39	18		99	17
18	ROOF-TOP A/C UNIT			1996	5,100	131	39	131		682	18
19	WINDOWS			1996	1,080	28	39	28		143	19
20	WINDOWS			1997	14,040	363	39	363		1,630	20
21	WALK-IN FREEZER			1997	3,196	82	39	82		359	21
22	WINDOWS			1998	8,370	217	39	215	(2)	787	22
23	FLOORING / TILE / CARPETING			1998	3,396	87	39	87		318	23
24	CEILING TILES			1998	2,213	57	39	57		183	24
25	ROOF REPAIRS / ROOFTOP A/C			1999	33,838	867	39	868	1	2,062	25
26	ROOF REPAIRS			2000	13,505	346	39	346		649	26
27	INSTALLATION CORNICES & SHEERS			2000	3,280	119	27.5	119		184	27
28	DRAPERY PANELS			2000	2,170	598	20	109	(489)	218	28
29	CARPETING OFFICES			2001	1,814	363	20	91	(272)	91	29
30	INSTALLED ROOF TOP UNIT			2001	6,992	11	27.5	11		11	30
31											31
32	COUNTRYSIDE HEALTHCARE CENTER LLC: ROOF			2001	250,900	2,662	39	2,662		2,662	32
33											33
34	CAREPLUS MANAGEMENT INC: LEASEHOLD IMPROVEMENT					120		120			34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number COUNTRYSIDE HEALTHCARE CENTER # 0036632 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 5,876,113	$ 148,659		$ 147,936	$ (723)	$ 545,295	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number COUNTRYSIDE HEALTHCARE CENTER # 0036632 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 248,301	$ 27,115	$ 20,361	$ (6,754)	3-15	$ 117,253	71
72	Current Year Purchases	27,947	5,589	2,217	(3,372)	10-15	2,217	72
73	Fully Depreciated Assets				0			73
74	RELATED PARTY-ALLOC SL DEPR		52,095	52,095	0			74
75	TOTALS	$ 276,248	$ 84,799	$ 74,673	$ (10,126)		$ 119,470	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$ 0		$	76
77							0			77
78							0			78
79							0			79
80	TOTALS			$ 0	$ 0	$ 0	$ 0		$ 0	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 6,545,111	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 233,458	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 222,609	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (10,849)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 664,765	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number COUNTRYSIDE HEALTHCARE CENTER # 0036632 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A-RELATED PARTY

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 37,960 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY	1999 DODGE RAM	$ 620.00	$ 7,690	17
18					18
19					19
20					20
21	TOTAL		$ 620.00	$ 7,690	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number COUNTRYSIDE HEALTHCARE CENTER # 0036632 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? ☐ YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM ☐
- IN OTHER FACILITY ☐
- COMMUNITY COLLEGE ☐
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM ☐
- IN OTHER FACILITY ☐
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	Nurse Aide Competency Tests				0
9	TOTALS	$ 0	$ 0	$ 0	$ 0
10	SUM OF line 9, col. 1 and 2 (e)	$ 0			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number COUNTRYSIDE HEALTHCARE CENTER # 0036632 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 1,251	$		$ 1,251	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			10,977			10,977	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				24,653		24,653	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	MEDICAL SUPPLIES Other (specify): LABS/RENTALS	39-2 39-2					3,466 1,719		3,466 1,719	13
14	TOTAL			$		$ 12,228	$ 29,838		$ 42,066	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number COUNTRYSIDE HEALTHCARE CENTER **#** 0036632 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2001 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (123,564)	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,300,028		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	99,165		6
7	Other Prepaid Expenses	9,759		7
8	Accounts Receivable (owners or related parties)	60,000		8
9	Other(specify): Real Estate Tax Escrow	206,229		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,551,617	$ 0	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	216,688		15
16	Equipment, at Historical Cost	276,248		16
17	Accumulated Depreciation (book methods)	(242,100)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 250,836	$ 0	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,802,453	$ 0	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 388,435	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	398,737		29
30	Accrued Salaries Payable	93,192		30
31	Accrued Taxes Payable (excluding real estate taxes)	10,655		31
32	Accrued Real Estate Taxes(Sch.IX-B)	412,960		32
33	Accrued Interest Payable	13,958		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,317,937	$ 0	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 0	$ 0	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,317,937	$ 0	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,484,516	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,802,453	$ 0	48

***(See instructions.)**

Facility Name & ID Number COUNTRYSIDE HEALTHCARE CENTER # 0036632 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,494,704	1
2	Restatements (describe):		2
3	IL REPLACEMENT TAX	(11,594)	3
4	PRIOR YEAR ADJUSTMENT	732	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,483,842	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	674	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 674	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 0	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,484,516	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number COUNTRYSIDE HEALTHCARE CENTER # 0036632 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,421,554	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,421,554	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 0	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 0	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 0	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**SETTLEMENT WITH PRIOR OWNERS**	(8,500)	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (8,500)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,413,054	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	940,236	31
32	Health Care	2,021,198	32
33	General Administration	1,727,639	33
	B. Capital Expense		
34	Ownership	1,573,383	34
	C. Ancillary Expense		
35	Special Cost Centers	42,066	35
36	Provider Participation Fee	107,858	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,412,380	40
41	**Income before Income Taxes (line 30 minus line 40)****	674	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 674	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.** **TAX RETURN NOT YET PREPARE**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number COUNTRYSIDE HEALTHCARE CENTER # 0036632 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,818	3,181	$ 80,443	$ 25.29	1
2	Assistant Director of Nursing	495	495	11,414	23.06	2
3	Registered Nurses	10,279	10,652	217,513	20.42	3
4	Licensed Practical Nurses	26,783	28,015	517,717	18.48	4
5	Nurse Aides & Orderlies	73,388	80,124	663,428	8.28	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,776	7,557	64,914	8.59	8
9	Activity Director	2,237	2,504	31,588	12.62	9
10	Activity Assistants	6,922	7,480	51,241	6.85	10
11	Social Service Workers	16,216	17,065	254,271	14.90	11
12	Dietician					12
13	Food Service Supervisor	1,474	1,584	19,011	12.00	13
14	Head Cook	4,899	5,448	41,376	7.59	14
15	Cook Helpers/Assistants	13,283	14,958	100,214	6.70	15
16	Dishwashers					16
17	Maintenance Workers	4,029	4,402	45,015	10.23	17
18	Housekeepers	19,439	21,374	145,986	6.83	18
19	Laundry	7,930	9,187	62,282	6.78	19
20	Administrator	3,894	4,159	100,069	24.06	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,570	3,755	55,981	14.91	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,085	1,156	10,285	8.90	31
32	Other Health Care(specify)					32
33	Other(specify) MARKETING	1,840	1,959	38,410	19.61	33
34	TOTAL (lines 1 - 33)	207,357	225,055	$ 2,511,158 *	$ 11.16	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 7,200	1-3	35
36	Medical Director	O	5,000	9-3	36
37	Medical Records Consultant	N	2,709	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	3,245	10-3	39
40	Physical Therapy Consultant	L	7,200	10a-3	40
41	Occupational Therapy Consultant	Y	7,200	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	F	0	11-3	44
45	Social Service Consultant	E	722	12-3	45
46	Other(specify)	E			46
47	PSYCHO-SOCIAL	S	400	10-3	47
48					48
49	TOTAL (lines 35 - 48)		$ 33,676		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides		N/A		52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number COUNTRYSIDE HEALTHCARE CENTER # 0036632 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
MONIQUE MOORE	ADMIN	0	$ 100,069
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 100,069

B. Administrative - Other

Description	Amount
CAREPLUS MGMT., INC - MANAGEMENT FEES	$ 444,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 444,000

C. Professional Services

Vendor/Payee	Type	Amount
CARE PLUS	DATA PROCESSING	$ 14,400
HDSI	DATA PROCESSING	1,728
AMERICAN DATA	DATA PROCESSING	2,400
CARE PLUS	ADMIN. CONSULTANT	186,000
KBKB	ACCOUNTING FEES	30,300
MEYER MAGENCE	LEGAL FEES	13,323
RICHARD PEELO	MEDICARE CONSULT	3,750
PERSONNEL PLANNERS	UC CONSULTANT	2,175
ECONOCARE	PURCHASE CONSULTANT	2,955
NATIONAL DATACARE	DATA PROCESSING	815
SACHNOFF & WEAVER	LEGAL FEES	224
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 258,070

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 31,822
Unemployment Compensation Insurance	29,258
FICA Taxes	190,248
Employee Health Insurance	56,837
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	4,816
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	1,233
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 314,214

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	38,524
Health Care Worker Background Check	456
(Indicate # of checks performed 38)	
MARKETING/ADV/PROMO	12,720
TRUST FEES/CONTRIBUTIONS	3,184
MGMT CO ALLOCATION	5,455
DUES & SUBSCRIPTIONS	7,035
LICENSES & PERMITS	521
TRUST FEES/CONTRIBUTIONS	(3,184)
Less: Public Relations Expense	(0)
Non-allowable advertising	(11,548)
Yellow page advertising	(1,172)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 52,191

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	0
MGMT CO ALLOCATION	630
Seminar Expense	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 630

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number COUNTRYSIDE HEALTHCARE CENTER # 0036632 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	PAINT/DECORATING	1998	$ 1,671	3	$ 279	$ 557	$ 557	$ 278	$	$	$	$	$
2	PAINT/DECORATING	2000	2,331	3			389	777	777	388			
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 4,002		$ 279	$ 557	$ 946	$ 1,055	$ 777	$ 388	$	$	$

Facility Name & ID Number COUNTRYSIDE HEALTHCARE CENTER # 0036632 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL LONG TERM CARE-$6959**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ _____ Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **107,858**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID#: COUNTRYSIDE HEALTHCARE CENTER #0036632 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	7,200	
	REPAIRS & MAINTENANCE		3,009	
			0	10,209
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
			0	0
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		25,978	
	ELECTRICITY		68,819	
	WATER		26,793	
	CABLE TV - LOBBY		443	
			0	122,033
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		4,185	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		15,064	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		3,795	
	FIRE SERVICE		1,764	
			0	
			0	
			0	24,808
7	**OTHER**			
	SCAVENGER		11,007	
	SECURITY SERVICE		108	11,115
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	5,000	5,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		321	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	400	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	2,709	
	PHARMACY CONSULTANT	XVIII B 39-2	3,245	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
			0	
			0	6,675
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		5,427	
	SPEECH THERAPY SERVICES		324	
	OCCUPATIONAL THERAPY SERVICES		608	
	THERAPY CONTRACT SERVICE		5,255	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	7,200	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	7,200	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	26,014
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0	
			0	0
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	722	
			0	722
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number COUNTRYSIDE HEALTHCARE CENTER **#0036632** **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	444,000	444,000
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	19,343	
	ADMINISTRATIVE CONSULTANTS	XIX C	186,000	
	PROFESSIONAL FEES	XIX C	52,727	
			0	258,070
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	11,548	
	EMPLOYEE WANT ADS	XIX F	38,524	
	CONTRIBUTIONS	VI 20 XIX F	500	
	DUES & SUBSCRIPTIONS	XIX F	7,035	
	LICENSES & PERMITS	XIX F	721	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	1,172	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	325	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	2,359	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	456	62,640
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES			
	EQUIPMENT REPAIR & MAINTENANCE		11,723	
	OUTSIDE CLERICAL SERVICES		118,200	
	PENALTIES / OVERDRAFT CHARGES	VI 18	22,637	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		24,022	
	MESSENGER SERVICE		961	
			0	177,543

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	190,248	
	UNEMPLOYMENT COMPENSATION	XIX D	29,258	
	WORKERS COMPENSATION INSURANC	XIX D	31,822	
	HOSPITALIZATION INSURANCE	XIX D	56,837	
	EMPLOYEE BENEFITS - OTHER	XIX D	4,816	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	401 K EXPENSE	XIX D	1,233	
	CHICAGO HEAD TAX	XIX D	0	314,214
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		2,323	2,323
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
			0	
			0	0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		2,092	2,092
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		253,386	253,386
27	**OTHER**			
	BAD DEBTS	VI 24	0	
			0	0

GRAND TOTAL COLUMN 3 OTHER 1,720,844

COUNTRYSIDE HEALTHCARE CENTER
EMPLOYEE MEAL RECLASSIFICATION
12/31/2001

TOTAL FOOD PURCHASE	228,232	PATIENT MEALS	182445
LESS SALES TAX	(1,279)	ADD EMPLOYEE MEALS	0
NET FOOD	226,953	TOTAL MEALS/YEAR	182445
TOTAL PATIENT CENSUS	60,815	NET FOOD	226953
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	182445
TOTAL PATIENT MEALS	182445	COST PER MEAL	1.24
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
TOTAL EMPLOYEE MEALS	0		